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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **STEVEN CERVI-SKINNER, M.D.,** Holder of License No. 26268 For Practice of Allopathic Medicine in the State of Arizona.	NO.: MD-05-1166A CIV. NO.: 07A-051166 **CONSENT AGREEMENT FOR DECREE OF CENSURE, PRACTICE RESTRICTION AND PROBATION**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Steven G. Cervi-Skinner, M.D. ("Respondent"), the parties agree to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter and that he has done so.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement or any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

7. Upon signing this Agreement, and returning this document (or a copy thereof) to the Counsel for the Board, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the documents. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the

national Practitioner Data Bank and to the Arizona Medical Board's website.

10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27) (r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

12. ***Respondent has read and understand the condition(s) of probation.***

Steven G. Cervi-Skinner MD

STEVEN G. CERVI-SKINNER, M.D.

DATED: 1/7/2008

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 26268 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-1166A as a result of an investigation of a Physician Assistant ("PA").

4. On April 19, 2004, PA submitted a Notification of Supervision ("NOS") application in which Respondent agreed to be his supervising physician. Respondent and PA attested that PA would not write schedule II and III controlled substances beyond 14 days and that a proper recordation of all 14 day prescriptions for scheduled II and III controlled substances would be recorded and a copy of prescriptions written by PA would be included by patient medical records. The Arizona Regulatory Board of Physician Assistants approved the application and on April 21, 2004, Respondent began supervising PA.

5. PA saw patients at a clinic in Lakeside, Arizona. Respondent practices as a hospitalist in Phoenix, Arizona. In response to the Board's investigation, Respondent informed Board Staff he reviewed 80 to 100 patient charts weekly with PA and physically signed the medical record. However, during an investigational interview with Staff, Respondent stated there were several occasions where he and PA did not meet weekly to discuss case management or review patient charts.

6. A random review of six patient charts by Staff revealed that PA treated patients at a clinic for chronic pain management. During an investigational interview, Respondent acknowledged he is a hospitalist and that he has no knowledge of the Board's guidelines for chronic pain treatment. Respondent admitted to prescribing scheduled II controlled substances to patients at the Lakeside clinic without first conducting a physical examination. Respondent also allowed PA to treat patients that were not in Respondent's scope of practice as a hospitalist. There was no Board approved supervising physician's agent at the clinic.

PATIENT CJ

7. On June 3, 2004, a fifty-one year old female patient ("CJ") presented to PA complaining of dyspnea on exertion and fatigue and a history of severe rheumatoid arthritis ("RA"), chronic multiple joint pains, degenerative joint disease ("DJD"), chronic bronchitis, depression, anxiety, and gastroesophageal reflux disease. PA noted CJ was taking Premarin, Plaquenil, Elavil, Hydrocodone and Lexapro. PA examined CJ and noted she was a non-smoker and had swollen tonsils, erythemic and swollen cervical lymph nodes with wheezing in both lungs and smelled of strep. PA noted CJ's musculoskeletal examination was normal and did not note any rheumatoid deformities. PA's assessment was bronchitis, rheumatoid lung disease, severe RA, questionable cardiovascular involvement, depression/anxiety, hormone replacement therapy, and chronic pain medication usage. PA did not request CJ's medical records from her previous treating physicians to verify his assessment. PA planned to take throat cultures, but he did not document whether this was completed. PA prescribed Augmentin, Phenergan, codeine, and Advair.

8. On June 7, 2004, CJ presented to PA still fatigued and wheezing. PA's diagnosis remained unchanged from the June 3, 2004, office visit. PA again did not note any rheumatoid deformities. PA prescribed Lortab and Soma.

9. On June 17, 2004, CJ presented to PA complaining of shortness of breath and severe arthritis. PA's diagnoses remained unchanged. PA noted CJ would be disabled from her rheumatoid arthritis even though he did not perform a physical examination of her small and medium joints to determine this diagnosis. PA continued prescribing Augmentin, Phenergan, codeine, Advair, Lortab and Soma.

10. On July 26, 2004, CJ presented to PA for follow-up treatment and complaining of polyarthralgia (multiple joint pain). PA performed a musculoskeletal examination revealing decreased range of motion in the cervical and lumbar spine, bilateral shoulders and legs. PA's assessment was "[b]ack pain (postural), Fibromyalgia, [g]eneralized pain, [h]yperesthesia of skin, [l]imb pain..., Myalgia, Neuralgia, Psychogenic pain, radiculitis,

Sciatica, [m]ixed hyperlipidemia, chronic fatigue syndrome, generalized anxiety disorder, [o]besity..., [i]nsomnia associated with anxiety, depression..., lumbar facet syndrome, lumbar osteoarthritis, [l]umbar radiculitis, lumbar spinal stenosis, essential hypertension, reflux esophagitis, depressive disorder..., osteoarthrosis, generalized involving multiple sites, chronic obstruction lung disease, asthma [with chronic obstructive pulmonary disease], unspecified." There was no objective data in CJ's medical records indicating what information PA gathered to support these diagnoses. PA noted he "strongly encouraged" CJ to stop smoking even though at the June 3, 2004, visit PA noted she was a non-smoker and there was no indication she had started smoking. PA referred CJ to a cardiologist and pain and weight management specialists, but he only documented his referral to the cardiologist. PA signed his name on the referral document, but did not affix P.A.-C to his name.

11. On September 24, 2004, CJ presented to PA wheezing with basilar rhonchi and rales. PA performed a musculoskeletal examination that was normal. PA diagnosed CJ with bronchitis, possible pneumonia, DJD, RA and depression. PA prescribed Advair, Levaquin, small volume nebulizers, refilled her pain medications, ordered a urinalysis, and recommended follow-up in one week. CJ did not follow-up with PA.

12. An October 14, 2004, note in PA's handwriting and signed by PA states Respondent reviewed CJ's medical record. PA also documented a note in CJ's medication log statement Percocet and soma prescriptions were "written by [Respondent] and faxed to [the pharmacy]." Respondent informed Board Staff that when he reviewed the medical charts he would physically sign the records. There were no signatures from Respondent in CJ's medical record, indicating Respondent did not review the record.

13. The standard of care requires a supervising physician to provide proper supervision of a physician assistant's management of chronic pain and diagnosis.

14. Respondent deviated from the standard of care because he did not provide proper supervision of PA's management of CJ's chronic pain and PA's unsupported diagnosis for CJ.

15. Respondent's improper supervision could have led to CJ being at risk of

inadequate management for her chronic pain.

PATIENT DJ

16. On May 25, 2004, a fifty-three year-old male patient ("DJ") presented to PA with upper respiratory symptoms and for pain management and medications. PA noted DJ was taking MS Contin, a schedule II controlled substance and Lortab for breakthrough pain. PA did not examine or evaluate DJ's spine or the area of pain and he did not review DJ's previous treatment records or diagnostic tests. PA diagnosed DJ with degenerative disk disease ("DDD") in the spine, DJD, phantom limb pain in the right arm where DJ had a below the shoulder right arm amputation, and a history of multiple surgeries to the left hand, right shoulder and right knee. PA refilled DJ's Lortab and referred DJ to pain management specialists for MS Contin refills.

17. On June 25, 2004, PA called in Soma to the pharmacy, but there was no documentation as to why this was added to DJ's prescriptions.

18. On July 19, 2004, July 21, 2004,August 3, 2004, September 28, 2004, October 21, 2004, and March 7, 2005, DJ presented to PA for chronic pain and pain medication refills. PA did not note a history or present illnesses or verify the severity of DJ's chronic pain complaints. On August 4, 2004, a nursing note stated DJ was unable to see the pain management specialist and needed a MS Contin prescription. PA declined to write the prescription. DJ threatened that he would "probably...check himself into the hospital due to withdrawals." On October 18, 2004, PA asked Respondent to begin prescribing to DJ. In the meantime, PA provided DJ with an emergency prescription for MS Contin. On October 20, 2004, a nursing note stated DJ called requesting MS Contin and was informed that Respondent would write a prescription on October 22, 2005, and it would be ready for pick up on October 25, 2004. However, on October 21, 2004, DJ presented to PA to discuss pain medications. PA prescribed Demerol. He did not note a history of DJ's present illnesses and did not note the discussion between him and DJ. On October 22, 2004, Respondent prescribed MS Contin, Lortab, and Soma.

19. From October 22, 2005, to October 12, 2005, Respondent or PA authorized

refills for DJ's pain medications including MS Contin. On October 12, 2005, PA noted more of DJ's history of present illnesses that were not noted during the previous office visits, including back pain, Fibromyalgia, generalized pain, headache, hyperesthesia of the skin, limb pain, low back pain, Myalgia, neuralgia, psychogenic pain, radiculitis, cervical IVD degeneration, lumbar facet syndrome, lumbar osteoarthritis, lumbar radiculitis, and lumbar spinal stenosis.

20. PA wrote, but did not document in DJ's medical record or medication log, a prescription for ninety tablets of Hydrocodone. PA is not authorized to prescribe for more than fourteen days. On April 15, 2005, DJ attempted to fill the prescription, but the pharmacy only filled forty-five tablets every two weeks because PA lacked the authorization to prescribe for more than fourteen days. Also, several office visits did not contain signatures from Respondent, indicating Respondent did not review DJ's medical record. During the investigational interview with Staff, Respondent stated PA would sometimes bring the whole chart for review and sometimes PA would only bring one progress note for the patient, indicating Respondent at times may have reviewed only one progress note.

21. On March 9, 2006, the pharmacy informed Board Staff that PA wrote DJ a prescription for twenty-eight days of MS Contin. PA is not authorized to prescribe for more than fourteen days. The MS Contin prescription was not noted on the medication log and there were no copies of the prescription in DJ's medical record.

22. The standard of care requires a supervising physician to provided proper supervision of a physician assistant's management of chronic pain.

23. Respondent deviated from the standard of care because he did not provide proper supervision of PA's management of DJ's chronic pain.

24. Respondent's improper supervision could have led to DJ being at risk of inadequate management of his chronic pain.

PATIENT DF

25. On January 17, 2005, a fifty-three year-old wheelchair bound female patient ("DF") presented to a physician ("Physician") in PA's office for pain management with a

history of interstitial lung disease, non-insulin dependent diabetes, and motor vehicle accident with a head injury and complaining of continuous and severe chronic pain. Physician noted DF had taken Methadone, but stopped due to nausea and was going through withdrawal. Physician performed an examination revealing elevated blood pressure, decreased cervical spine range of motion and tenderness at the lumbar spine with "DJD changes" of the lumbar and thoracic spine and bilateral lower extremity edema. Physician's assessment was head, neck and back pain; Dermatomyositis (DM); bilateral lower extremity edema; elevated blood pressure secondary to pain; interstitial lung disease; early congestive heart failure (CHF); and DJD of the spine. Physician prescribed liquid Morphine sulfate (MSO4) and Oxycontin, both schedule II controlled substances.

26. On December 16, 2004, DF presented to Physician for more pain medications and an increase in her dosage. Physician declined and recommended DF see a pain management specialist. DF declined and complained of pain. Physician noted DF's blood pressure was elevated and prescribed Hydrochlorothiazide ("HCTZ") for hypertension and edema, liquid MSO4, Oxycontin and Phenergan.

27. On January 17, 2005, DF presented to PA. PA did not request DF's medical records from Physician and therefore did not note DF's history of present illnesses. PA performed an examination, but his notes are illegible. PA did, however, mark on DF's chart that her heart, lung, breast, abdomen, musculoskeletal and skin examination were abnormal. PA's assessment was headache, abdominal surgery, total hip replacement, fractured vertebrae, DDD, CHF, but the rest was illegible. PA prescribed a Zithromax pack, KCl (an anti-methamphetamine), and HCTZ. PA also prescribed Oxycontin twice per day and MSO4 every four to six hours, essentially doubling the initial two-week dose prescribed by Physician. There was no documentation in the assessment plan to increase DF's dose. Also, the prescription refill exceeded PA's fourteen-day prescribing limit. PA noted he reviewed DF's records with Respondent, but there was no signature by Respondent indicating he reviewed the records.

28. On January 26, 2005, DF returned for a follow-up visit. PA ordered an

echocardiogram revealing mild diminished CHF, moderate pulmonary hypertension, and an ejection fraction of 65%. DF's left ventricle was normal; she had mild concentric left ventricular hypertrophy, and a moderate tricuspid regurgitation. PA's examination notes revealed DF had severe range of mobility limitations in her neck and mid and lower back. PA recommended DF undergo a nuclear stress test 2D echo mode and noted she should see a renal specialist, but DF declined. PA therefore recommended a Coreg (a beta-blocker for treatment of HTN and heart failure). PA refilled DF's MSO4 and noted she was on Oxycontin twice per day. The prescription refill exceeded PA's fourteen day prescribing limit. There were no copies of the MSO4 prescription in the DF's medical record.

29. From February 15, 2005 to March 21, 2006, DF returned for follow-up visits and medication refills. PA noted she was on MS Contin twice per day, but did not note a history of present illness. PA also noted DF had clear lungs with a low oxygen saturation level, pain in her right arm, "severe range of mobility limitations," severe skull deformity, and decreased range of motion in her back and neck with accompanying pain. DF also had systolic ejection murmur and decreased breath sounds at the bases of her lungs. PA did not examine DF's spine or perform examinations to elicit painful abnormalities. PA prescribed MS Contin two every twelve hours, twice the amount prescribed on January 17, 2005; MSIR (immediate release Morphine); Phenergan and Norco (acetaminophen and hydrocodone) twice per day. There were no copies of the MSO4 and MSIR prescriptions in DF's medical record.

30. PA noted he reviewed DF's medical records with Respondent, but there were no signatures by Respondent on February 16, 2005, March 18, 2005, May 3, 2005, May 25, 2005, June 14, 2005, July 12, 2005, July 27, 2005, August 2, 2005, September 9, 2005, September 27, 2005, October 31, 2005, and March 21, 2006, indicating he reviewed DF's medical records. PA did not address DF's low oxygen saturation even though he knew she had pulmonary hypertension.

31. On July 27, 2005, DF returned for a follow-up visit complaining of "signs and symptoms of bowel obstruction vomiting coffee grounds." PA performed an abdominal

examination he described as normal. PA's assessment plan was severe/chronic pain and to send DF to the emergency department, but she refused. PA prescribed MS Contin.

32. On August 2, 2005, DF returned for a follow-up visit complaining of periumbilical pain and constipation and diarrhea for three days. PA performed an abdominal examination and noted hypoactive bowel sounds and tenderness. However, PA then noted "abdomen soft, nontender, bowel sounds x 4 without palpable masses." PA also performed a three way abdomen x-ray series revealing fecal impaction. PA's assessment was abdominal pain, gastroenteritis, diverticulitis of the colon, and tenderness of the abdominal wall of unknown etiology. PA ordered an abdominal ultrasound and without indication, informed DF to monitor her chest pain episodes closely to see if anything relieves the pain. PA also informed DF to go to the emergency department if the chest pain persisted and was not relieved by any measures.

33. From January 2005 to December 2005, PA signed DF's referrals, prescription authorizations and physicians' orders without identifying himself as a "P.A.-C." PA also signed as the physician on forms that were addressed to another physician. Also, several office visits did not contain signatures from Respondent, indicating Respondent did not review DF's medical record. During the investigational interview with Staff, Respondent stated PA would sometimes bring the whole chart for review and sometimes PA would only bring one progress note for the patient, indicating Respondent at times may have reviewed only one progress note.

34. The standard of care requires a supervising physician to provide proper supervision to a physician assistant's management of chronic pain and pulmonary problems for patient.

35. Respondent deviated from the standard of care because he did not provide proper supervision of PA's management of DF's chronic pain and pulmonary problems.

36. Respondent's improper supervision of PA may have resulted in treatment delay for DF for unrecognized and unaddressed low oxygen saturation.

PATIENT MF

37. On June 8, 2004, a thirty-year old female patient ("MF") presented to PA. PA had two typewritten notes for this office visit. The first note listed MF as allergic to Hydrocodone and her history of present illnesses included increased neck and shoulder pain associated with a headache, "severely debilitating" abdominal pain and a history of depression, C spine fracture, and illegal drug use. The second note did not list these items. The first note listed MF's current medication as Oxycontin and noted she was intolerant of pills. The second note listed MF's medications as Motrin and Hydrocodone and does not mention that she was intolerant of pills. The second note stated PA performed a soft tissue osteopathic manipulation, but the first note did not list any procedures. The supervising physician may only delegate the same duties that are within the scope of the supervising physician's practice. At this time, Respondent was PA's supervising physician and he is a hospitalist and is not trained to perform soft tissue osteopathic manipulation. Therefore, PA was not authorized to perform a soft tissue manipulation. The first note stated PA did not order x-rays, a magnetic resonance imaging ("MRI"), electrocardiogram ("EKG"), or echocardiogram ("ECG"). PA also did not refer MF to a neurologist, but referred her to a gynecologist. However, the second note stated PA ordered an MRI of the spine (cervical and lumbar), a chest x-ray, an EKG, and an ECG and that he referred MF to a neurologist, a pain management specialist, but not to a gastroenterologist or gynecologist. PA's referrals for abdominal ultrasounds and examinations contained PA's stamped signature without "P.A.-C." affixed on the physician signature line.

38. On July 8, 2004, July 23, 2004, and October 15, 2004, MF presented to PA for follow-up appointments and pain medication refills. PA either noted minimal or no history of present illnesses. PA performed a physical examination showing no range of motion in MF's neck or lumbar spine and a systolic ejections murmur. PA diagnosed MF with DDD, DJD, hyperlipidemia, chronic neck or back pain and depression. On July 8, 2004, PA prescribed Lipitor, but discontinued it on July 23, 2004, for undocumented reasons and prescribed Advicor.

39. From June 8, 2004, to July 23, 2004, PA prescribed Oxycodone four times a day, but replaced Oxycodone with Hydrocodone on August 10, 2004, after MF was unable to afford the Oxycodone.

40. On November 19, 2004, MF presented to PA pregnant. PA advised MF to stop taking the pain medications until it was approved by her obstetrician and gynecologist.

41. On December 6, 2004, MF presented to PA for follow-up after a weekend emergency department visit. At the emergency department, MF requested narcotics because she was out of them. PA noted he advised MF to stop taking the pain medications and informed her to be admitted to the hospital for withdrawal symptoms.

42. The standard of care requires a supervising physician to provide proper supervision of a physician assistant's prescribing of schedule II and III controlled substances.

43. Respondent deviated form the standard of care because he did not provide proper supervision of PA's prescribing of Oxycodone and Hydrocodone for MF.

44. Respondent's improper supervision could have led to MF being at risk of inadequate management of her chronic pain.

PATIENT PK

45. On March 9, 2005, a forty-nine year old female patient ("PK") presented to PA complaining of stomach pain, intermittent nausea, and diarrhea and history of "ulcerative colitis." PA examined PK and noted mid epigastric tenderness. PA also noted PK was allergic to Phenergan. PA prescribed Norco and Flaygl even though there was no objective data gathered to support prescribing these medications. PA did not put a copy of the Norco prescription in PK's medical record.

46. From March 30, 2005, to July 18, 2005, PK presented to PA with complaints that he noted, but they are difficult to read. PA also noted little historical information and he did not request a copy of PK's medical records from prior treating physicians. PA performed an abdominal examination that was normal, but advised PK to see a gastroenterologist and prescribed Norco. PA diagnosed PK with DDD, Crohn's disease

47. From July 28, 2005, to October 19, 2005, PK presented to PA complaining of

nausea and vomiting and presented again on September 28, 2005, and October 19, 2005, complaining of nausea and vomiting with a headache. PA did not assess the reason for PK's vomiting and nausea, but prescribed Phenergan, even though he noted PK was allergic to the medication; Keflex, without indicating his reason for prescribing it; and Norco. PA also referred PK for breast ultrasounds, colonoscopies, and to an ophthalmologist. Each referral contained PA's signature, but he did not affix "P.A.-C." to his name and PA and his staff failed to identify him as a physician assistant.

48. The standard of care requires a supervising physician to provide proper supervision of a physician assistant's prescribing of schedule II controlled substances.

49. Respondent deviated from the standard of care because he did not properly supervise PA's prescribing of Norco for PK.

50. Respondent's improper supervision could have led to PK being at risk of inadequate management of her chronic pain.

51. On July 5, 2006, Respondent was noticed for violations regarding billing concerns and was asked to provide an explanation of benefits. Respondent did not respond to the notice.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(a) ("[v]iolating any federal or state laws or rules and regulations applicable to the practice of medicine."), specifically, A.R.S. § 32-2533(D) ("[a] supervising physician shall develop a system for recordation and review of all instances in which the physician assistant prescribes fourteen day prescriptions of schedule II or schedule III controlled substances..."); A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient."); A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public."); A.R.S. § 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence

or negligence resulting in harm to or the death of a patient."); A.R.S. § 32-1401(27)(dd) ("[f]ailing to furnish information in a timely manner to the board or the board's investigators or representatives if legally requested by the board."); and A.R.S. § 32-1401(27)(ii) ("[l]ack of or inappropriate direction, collaboration or direct supervision of a medical assistant or a licensed, certified or registered health care provider employed by, supervised by or assigned to the physician.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Decree of Censure for failure to properly supervise a Physician Assistant, for failure to maintain adequate medical records, for failure to adequately manage multiple patients, for failure to properly record schedule II and III controlled substances and for failure to furnish information to the Board in a timely manner.

2. Respondent is placed on probation for **thirty years** with the following terms and conditions:

A. Respondent shall not supervise Physician Assistants for **thirty years**. The Board may require any combination of Staff approved psychiatric and/or psychological evaluations or successful passage of the Special Purpose Licensing Examination or other competency examination/evaluation or interview it finds necessary to assist it in determining Respondent's ability to safely and competently return to supervising Physician Assistants.

B. Respondent shall submit annual declarations under penalty or perjury on forms provided by the Board stating whether there has been compliance with all the conditions of probation. The declarations must be submitted on or before the 15th of July of each year.

C. Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court order criminal probation, payments and other orders.

D. Tolling

In the event Respondent should leave Arizona to reside or practice outside the State of

Arizona or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

3. This Order is the final disposition of case number MD-05-1166A.

4. Upon approval of this Order by the Board, CIV NO. 07A-051166 before the Office of Administrative Hearings, will be dismissed as moot.

DATED AND EFFECTIVE this 7TH day of FEB., 2008.

ARIZONA MEDICAL BOARD

(SEAL)

BY _____
Lisa S. Wynn
Executive Director

ORIGINAL OF THE FOREGOING FILED
this 7th day of February, 2008, with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, Arizona 85258

EXECUTED COPY OF THE FOREGOING DELIVERED ELECTRONICALLY AND BY FIRST CLASS MAIL this 7th day of July, 2008, to:

Cliff J. Vannell
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By: [signature]